By Kimberly Hefling and Ben Evans
Associated Press

WASHINGTON (AP) - Fewer than half of Veterans Affairs centers given a surprise inspection last month had proper training and guidelines in place for common endoscopic procedures such as colonoscopies - even after the agency learned that mistakes may have exposed thousands of veterans to HIV and other diseases.

The findings, from the VA's inspector general and obtained by The Associated Press, suggest that errors in colonoscopies and other minimally invasive procedures performed at VA facilities may be more widespread than initially believed.

The report is slated to be released Tuesday at a hearing before a House Veterans Affairs subcommittee, in which VA officials are scheduled to take questions. Rep. Harry Mitchell, D-Ariz., who will chair the hearing, on Monday called the situation a "damaging blow to the trust veterans place in the VA."

Mitchell said in a statement he wants to learn what the VA is doing to protect those potentially exposed and about what changes have been put in place to prevent similar mistakes.

The random inspections were conducted May 13-14 at 42 VA medical centers around the country. They found that just 43 percent of the centers have standard operating procedures in place and have properly trained their staffs for using endoscopic equipment.

The investigation comes months after the discovery of a mistake at Murfreesboro, Tenn., led to a nationwide safety campaign at the VA's 153 medical centers calling attention to potential infection risks from improperly operating and sterilizing the equipment.

Along with Murfreesboro, the agency has said mistakes were identified at a Miami center and at an ear, nose and throat clinic in Augusta, Ga. In February the agency started warning about 10,000 former patients at those facilities, some who had colonoscopies as far back as 2003, to get blood tests for HIV and hepatitis.

The VA says the chance of infection is remote. As of Friday, the VA reported that six veterans taking the follow-up blood checks tested positive for HIV, 34 tested positive for hepatitis C and 13 tested positive for hepatitis B. But there is no way to prove whether the infections came from VA procedures, and some experts say most or all of the infections probably already existed.

The VA has acknowledged that the mistakes were caused by human error. Agency spokeswoman Katie Roberts did not immediately respond to a request for comment on the report.